BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: MAHFOUZ MICHAEL, M.D., Physician's and Surgeon's Certificate No. A34248, Respondent.	Case No. 800-2014-008113 OAH No. 2017120959

DECISION AFTER NON-ADOPTION

Administrative Law Judge (ALJ) Carla L. Garrett heard this matter on August 14, 15, 16, and 17, 2017, at Los Angeles, California.

Beneth A. Browne, Deputy Attorney General, represented Complainant Kimberly Kirchmeyer (Complainant), Executive Director of the Medical Board of California (Board). Craig B. Garner, Attorney at Law, represented Mahfouz Michael, M.D. (Respondent), who was present at the hearing.

During the hearing, Complainant's motion to amend the Accusation was granted, as follows: on page 4, paragraph 11, line 14, "54" is changed to "55"; on page 5, paragraph 13, line 5, "19/30" is changed to "20/30"; and on page 7, paragraph 22, line 15, "the same date" is changed to "April 23, 2014."

On August 16, 2017, Respondent moved for a protective order requesting that all exhibits, transcripts, recordings, and other documents filed with OAH in connection with the above-referenced matter, be placed under seal because the documents contain confidential information which is protected from disclosure to the public. Redaction of the documents to obscure this information was not practicable and would not have provided adequate privacy protection. Complainant did not oppose the motion. In order to protect the privacy of the various individuals identified in the documents and

to prevent the disclosure of confidential information, the ALJ issued a Protective Order placing the following under seal after their use in preparation of this Decision: all exhibits, except jurisdictional documents (Exhibits 1 through 3), written factual stipulations (Exhibit 48), the protective order request (Exhibit 49), and witness names on confidential names list contained in the record. Those documents shall remain under seal and shall not be opened, except as provided by the Protective Order. A reviewing court, parties to this matter, their attorneys, and a government agency decision maker or designee under Government Code section 11517 may review the documents subject to the protective Order provided that such documents are protected from release to the public.

Oral and documentary evidence was received. The record remained open to give Respondent an opportunity to submit a written closing brief by August 25, 2017, and to give Complainant an opportunity to file a written rebuttal brief by September 1, 2017.[1] Respondent and Complainant submitted timely closing and rebuttal briefs, respectively. The record was closed on September 1, 2017, and the matter was submitted for decision.

Panel B of the Board declined to adopt the proposed decision and on November 6, 2017, issued an Order of Non-Adoption. The date for submission of written argument was fixed, and written argument was submitted by both Complainant and Respondent. On January 18, 2018, Panel B heard the oral arguments of the parties, and Respondent was present. Having considered the arguments submitted as well as the administrative record, the Panel makes and enters the following as its decision in the matter.

FINDINGS OF FACT[2]

1. Complainant made the Accusation in her official capacity as Executive Director of the Board, alleging that Respondent had engaged in acts of gross negligence, repeated negligent acts, false representations, inadequate and inaccurate medical records, and general unprofessional conduct.

2. The Board issued Physician's and Surgeon's Certificate Number A34248 to Respondent on August 3, 1979. The certificate is scheduled to expire on March 31, 2019. Respondent has enjoyed a blemish-free 38-year career.

3. On July 9, 2014, the Board received a complaint alleging Respondent had engaged in fraudulent activities regarding six patients (Patients *CE*[3], NC, EC, *IL*, MA, and AV) in connection with his execution of Medical Certification for Disability

[1] Complainant presented an oral closing argument on the final day of the hearing.
[2] The Factual Findings represent findings reached by the ALJ combined with factual stipulations set forth in Exhibit 48.
[3] Patients are identified by their initials to protect their privacy.

Exceptions forms, also known as Form N-648, submitted to the Department of Homeland Security (DHS) on their behalf. Form N-648 is used to provide evidence to DHS that an applicant for citizenship has a physical or developmental disability or mental impairment that has lasted, or is expected to last, 12 months or more, that prevents him or her, even if provided a reasonable accommodation, from satisfying the English language and/or civics requirements. Form N-648 requires that all questions or item s be answered "fully and accurately" and that "only medical doctors, doctors of osteopathy, or clinical psychologists licensed to practice in the United States ... are authorized to certify the form." (Exhibit 6, page 1.) Finally, Form N-648 provides that "[w]hile staff of the medical practice associated with the medical professional certifying the form may assist in its completion; the medical professional is responsible for the accuracy of the form's content." *(Id.)*

4. On December 30, 2014, Investigator Gregory Saeki of the Health and Quality Investigation Unit of the Division of Investigation, visited Respondent's clinic (San Miguel Medical Center) and issued compliancy letters requesting medical records of the subject patients, medic al releases signed by the subject patients, and certification of records forms.

5. On January 21, 2015, in response to In,lestigator Saeki's requests for medical records, Respondent's office submitted the medical records of Patients CE (9 pages), NC (131 pages), JL (70 pages), MA (143 pages), and AV (203 pages). On February 5, 2015, Respondent's office submitted the medical records of Patient EC (70 pages). With the submission of the medical records, Respondent 's office manager, Connie Aguilar, executed a Certification of Records form for each patient declaring under penalty of perjury that the submitted records were "complete records" and were "prepared and maintained in the ordinary course of business ...at or near the time of the acts, conditions or events described by such records." (Exhibits 24-29.) None of the medical records submitted on January 21, 2015 or February 5, 2015, included any copies of Form N-648 or its accompanying documents, such as copies of mini mental state examination (MMSE) results.[4]

6. On April 15, 2015, Respondent's office submitted additional medical records of Patients CE (7 page s), NC (7 pages), EC (7 pages), JL (7 pages), MA (22 pages), and AV (21 pages). The medical records included a Form N-648 and MMSE results for each of these patients.

7. Ms. Aguilar testified at hearing and explained that in response to the request for the patients' medical records; she printed them from the office's electronic medical records (EMR) computer system. Ms. Aguilar further explained that she did not include immigration documentation (i.e., Form N-648 and accompanying

[4] MMSE results and their import are discussed in more detail below.

documents) with the initial document production because they were stored in a separate file in a separate cabinet. When Respondent's office discovered it had not included the immigration documents with the initial production, Respondent's office provided them on April 15, 2015.

Patient CE

8. On April 10, 2014, Patient CE, a Spanish-speaking 55-year-old female patient, presented at Respondent's clinic complaining of shoulder pain. Respondent's Physician's Assistant LA[5] (PA-LA) met with Patient CE and noted in Patient CE's medical chart the following: "rt shoulder pain x 3 weeks, since after fall, pt is experiencing memory deficit, pt does not read, speak neither write English." PA-LA did not include any further details regarding Patient CE's history. Under the "assessment" section of the medical notes, PA-LA stated "memory deficit, hypertension, gastritis, and osteoarthritis as well as right shoulder pain," but provided no details to document that he had performed a physical examination and evaluation of the right shoulder, or to substantiate that Patient CE had "memory deficit." Under the "plan" section of the medical notes, PA-LA stated "refer to neurologist, mini mental state exam [MMSE]," and various lifestyle recommendations."

9. On April 17, 2017, Patient CE returned to Respondent's clinic for a follow-up visit. The medical notes corresponding to Patient CE's visit indicate that Patient CE had gone to school in Guatemala up to the second grade, and note that Patient CE could not read, write, or speak English. Additionally, the medical notes state that Patient CE was attending school but was unable to retain new information or concepts. The medical notes also state in the "assessment section" the following: "normal routine history and physical, normal routine history and physical adult, essential hypertension, obesity and memory deficit." The medical notes reflected no diagnosis or reason for the "memory deficit" cited.

10. Patient CE's medical records note that Patient CE underwent a MMSE administered on April 23, 2014, which revealed a score of 20 out of 30, indicating severe impairment.

11. On April 23, 2014, PA-LA completed a Form N-648 for Patient CE. PA-LA listed the reasons for Patient CE's disability as memory deficit, hypertension, osteoarthritis, obesity and gastritis. PA-LA noted on the form that Patient CE's MMSE score was 20 out of 30, and listed genotype disorders as an etiology of memory deficit. PA-LA further stated on Form N-648 that:

[5] This Physician's Assistant is identified by initials to protect his privacy.

"[Memory loss is a] progressive disease that may cause cerebral function to diminish and it is always irreversible. It can be partial or complete or it can produce concentration deficit. The loss of memory can be caused by psychological factors, post-traumatic stress, or after experiencing highly stressing events."

(Exhibit 6, page 8.)

12. PA-LA also stated on Form N-648 that Patient CE required assistance with basic daily needs of life, such as cooking, shopping, and transportation, even though Patient CE's medical chart included no documentation of such. Additionally, PA-LA noted on Form N-648 that Patient had epilepsy, but such a diagnosis was not mentioned in Patient CE's medical records.

13. After PA-LA completed Form N-648, Respondent signed it under penalty of perjury, certifying that Patient CE was disabled for DHS purposes, and therefore should be exempted from having to satisfy the English language and/or civics requirements for obtaining citizenship.

Patient NC

14. On December 14, 2010, Patient NC presented to Respondent's clinic to address diabetes and hypertension. PA-LA treated Patient NC on October 7, 2011 and June 12, 2012. On March 1, 2013, a different physician's assistant met with Patient NC andnoted in Patient NC's chart, "Memory unimpaired in nml conversation." PA-LA saw Patient NC on April 1, 20 13, October 17, 2013, and January 22, 2014.

15. Patient NC's medical records indicate that Patient NC underwent a MMSE administered on April 23, 2014, which revealed a score of 19 out of 30, indicating severe impairment.

16. On April 23, 2014, Respondent signed Form N-648, under penalty of perjury, certifying that Patient NC was disabled for DHS purposes, and therefore should be exempted from having to satisfy the English language and/or civics requirements for obtaining citizenship. The form stated that Patient NC had a memory disorder and that the memory disorder itself was a disease that causes brain damage. However, Patient NC's medical chart mentions nothing about a memory disorder. Additionally, the form states that Patient NC suffers from anxiety that limits Patient NC's ability to learn, even though such anxiety is not documented in Patient NC's chart. The form additionally states that Patient NC was referred to a neurologist, but the purported referral is not documented in Patient NC's chart. Moreover, the form states that Patient NC's MMSE score was 20 out of 30.

Patient EC

17. On January 27, 2012, Patient EC presented at Respondent's clinic with

diabetes, hypertension, and osteoarthritis, and was treated at Respondent's clinic on multiple occasions.

18. On February 17, 2013, Patient EC complained of tremors, prompting Respondent's clinic to refer Patient EC to a neurologist to rule out Parkinson's disease. Patient EC's chart does not document whether Patient EC visited a neurologist or whether Patient EC's issue with tremors had been addressed.

19. On April 6, 2014, Patient EC presented at Respondent's clinic with abdominal pain. PA-LA treated Patient EC, failed to chai1 his diagnosis regarding Patient EC's abdominal pain, but prescribed an antibiotic (Flagyl).

20. On April 23, 2014, Respondent signed Form N-648, under penalty of perjury, certifying that Patient EC was disabled for DHS purposes, and therefore should be exempted from having to satisfy the English language and/or civics requirements for obtaining citizenship. The form states that Patient EC suffered a memory disability and lists diagnoses of epilepsy, memory deficit, and genotype disorders, even though those diagnoses are not reflected in Patient EC's chart. Additionally, the form notes that Patient EC's MMSE score was2 0 out of 30.

Patient JL

21. On February 26, 2013, Patient JL presented at Respondent's clinic with diabetes, hypertension, and osteoarthritis, and was treated at Respondent's clinic on multiple occasions.

22. On April 22, 2014, a physician other than Respondent treated Patient JL at Respondent's clinic, and performed a mammogram and a pap smear. Respondent signed Form N-648, under penalty of perjury, certifying that Patient JL was disabled for DHS purposes, and therefore should be exempted from having to satisfy the English language and/or civics requirements for obtaining citizenship. The form states Patient JL suffered a memory disability and listed diagnoses of epilepsy, memory deficit, and genotype disorders, even though those diagnoses were not reflected in Patient JL's chart. The form indicates that Patient JL had a memory disorder and that that memory disorder itself was a disease that causes brain damage. The form additionally notes that Patient JL' s MMSE score was 20 out of 30, although the results of the MMSE purportedly taken by Patient JL, as produced pursuant to the records demand described in Factual Findings 4 through 6, revealed results of 19 out of 30.

Patient MA

23. On June 11, 2012, Patient MA, a 66 year-old woman, first presented at Respondent's clinic and was diagnosed with hypertension, obesity, and bradycardia. Respondent treated at Respondent's clinic on multiple occasions, and had a normal neurological exam noted at many visits. Patient MA was subsequently diagnosed with diabetes.

24. On June 17, 2012, PA-LA treated Patient MA for a cough. PA-LA noted in Patient MA's chart that Patient MA was "unable to learn questionary (sic) for U.S. citizenship." PA-LA noted in Patient MA's chart that Patient MA suffered a memory deficit, but listed no history or examination in Patient MA's chart regarding memory issues.

25. On August 14, 2013, PA-LA treated Patient MA for a cough, lower back pain, and a foot condition. PA-LA noted in Patient MA's chart that Patient MA was "unable to learn questionary *(sic)* for U.S. citizenship interview." PA-LA noted in Patient MA's chart that Patient MA suffered a memory deficit, but listed no history or examination in Patient MA's chart regarding memory issues. PA-LA noted a plan to refer Patient MA to a neurologist and perform a MMSE.

26. On September 10, 2013, PA-LA treated Patient MA when she came to Respondent's clinic for a medical visit. PA-LA noted in Patient MA's chart that Patient MA was "unable to learn questionary (sic) for U.S. citizenship." PA-LA noted that Patient MA could not read or write in English or Spanish and had a hearing deficit, and noted a plan to perform a MMSE.

27. On April 8, 2014, PA-LA treated Patient MA when she came to Respondent's clinic for a medical visit. PA-LA included additional history in Patient MA's chart. Specifically, PA-LA noted that Patient MA suffered a head injury and a hearing deficit, attended school to the sixth grade, and was occasionally forgetful. PA-LA diagnosed Patient MA with mild memory disturbance following organic brain damage, and noted a plan to perform a MMSE.

28. On April 14, 2014, Respondent signed Form N-648, under penalty of perjury, certifying that Patient MA was disabled for DHS purposes, and therefore should be exempted from having to satisfy the English language and/or civics requirements for obtaining citizenship. The form states that Patient MA suffered a memory deficit, had a history of head trauma, hypertension, diabetes, osteoarthritis, incontinence, and suffered a hearing deficit. The form ascribes Patient MA's disability to psychological factors or to post traumatic experience due to head trauma, and states the memory deficit was due to amyloid plaques as well as "lipoprotein E epsilon 4 genotype." (Exhibit 6, page4.) Patient MA's medical chart references no presence of amyloid plaques or lipoprotein E epsilon 4 genotype. The form also states that Patient MA's memory disorder itself was a disease that causes brain damage. The form additionally states that Patient MA underwent a MMSE which revealed a score of 20 out of 30.

29. Patient MA, who testified at hearing, denied suffering a memory deficit or disorder. In fact, at the time the form was completed, Patient MA had been caring for her husband on a daily basis, because he had been rendered disabled as a result of a stroke. As his caretaker, Patient MA regularly bathed her husband, cooked for him, and helped to dress him, among other things.

30. Patient MA paid "Eddie" of Respondent's office $300 for ensuring Form N-648 was completed on her behalf, but subsequently demanded a return of her money, because the form submitted to immigration was rejected, as it was not completed properly. For example, the form stated, in essence, that she was forgetful, which prompted immigration officers to ask Patient MA how she was able to cook and care for her husband everyday if she was supposedly forgetful.

31. Patient MA denied that she was forgetful. Patient MA also denied suffering from post-traumatic stress as represented on the form. While she concedes she suffered a head injury when she fell out of a tree when she was 13 years old, the only long-term medical issue stemming from her fall was a hearing deficit.

32. On September 22, 2014, Patient MA received treatment from a different physician in Respondent's clinic to address Patient MA's chief complaint of back pain. The physician documented a comprehensive examination, including a review of Patient MA's neurological status, in which the physician noted no neurological concerns or issues. Additionally, the physician mentioned nothing about memory issues or abnormalities, and documented a normal MMSE.

33. On December 30, 2013, Patient AV presented at Respondent's clinic and met with PA-LA. Patient AV had a history of moderately differentiated adenocarcinoma of the colon, and had been previously diagnosed with hypertension, osteoarthritis, and diabetes. Patient AV had low anterior resection surgery with colostomy placement. PA-LA performed a medication review.

34. On April 10, 2014, PA-LA met with Patient AV in follow up to an emergency room visit Patient AV experienced when he suffered abdominal pain. At the time of the office visit, Patient AV was in pain and on narcotic pain medications. PA-LA referred Patient AV to his oncologist. PA-LA made no neurology referral for Patient AV.

35. On April 10, 2014, Respondent signed Form N-648, under penalty of perjury, certifying that Patient AV was disabled for DHS purposes, and therefore should be exempted from having to satisfy the English language and/or civics requirements for obtaining citizenship. The form listed the reasons for Patient AV's disability as memory deficits, cancer, diabetes, hypertension, asthma, osteoarthritis, and anxiety. The form also cited lipid genotypes as a basis for Patient AV's memory deficit and asserted that diabetes and hypertension caused memory loss. The form listed an MMSE score of 20 out of 30, but no such test was documented in Patient AV's chart.

Expert Testimony

36. Pamela M. Davis, M.D., provided expert testimony on behalf of the Board. Dr. Davis, who has been a Board consultant since the 1990's, earned her bachelor's degree in microbiology from the University of California at Los Angeles (UCLA) in 1978, and her medical degree from UCLA School of Medicine in 1982. She completed her residency at Northridge Family Medicine Residency Program in 1985. Thereafter,

Dr. Davis served as a Clinical Instructor, Associate Director, and Acting Director at Northridge Hospital Medical Center, and has served in her current position since 2001 as the Director of Residency at Dignity Medical Center at N011hridge Hospital Family Medicine Residency Program. As the Director of Residency, Dr. Davis controls and directs the curriculum of the residents, which includes reviewing medical records.

37. On June 25, 2015, the Board requested that Dr. Davis review the medical records of Patients CE, NC, EC, JL, MA, and AV.

38. With respect to Patients CE, EC, and JL, after reviewing their respective medical records, Dr. Davis considered the standard of care for physicians that requires them to make truthful representations of history, physical diagnoses, and impressions regarding a patient. In that regard, Dr. Davis noted that Respondent signed a Form N-648 for Patients CE, EC, and JL that listed diagnoses, such as epilepsy and genotype disorders, that did not have any supporting medical documentation in their respective records. Similarly, with respect to Patients NC, MA, and AV, Respondent signed forms that listed memory disorder as a diagnosis, but no supporting medical documentation existed in the patients' respective medical records. Given these factors, Dr. Davis concluded that Respondent engaged in an extreme departure from the standard of care by failing to provide honest and reliable information as required.

39. Dr. Davis also considered the standard of care requiring physicians to be informed and up to date as to current medical knowledge and the current practice of medicine, particularly in areas of medicine that the physician uses in practice. Dr. Davis noted that Respondent made medical assertions that did not follow the community standard in memory disorders with respect to Patient CE. Specifically, Respondent signed Patient CE's Form N-648 which asserted that memory loss was a "progressive disease," which is contrary to medical fact. Dr. Davis explained that memory loss is not a disease, but rather is a symptom. Similarly, with respect to Patients NC, JL, and MA, Respondent signed Patients NC's, JL's, and MA's Form N-648 which asserted that memory disorder was a disease that causes brain damage. Dr. Davis explained that such assertions were contrary to medical fact, and they do not follow the community standard for memory disorders. Additionally, with respect to Patients MA and AV, the form states that the presence of lipid genotypes serves as a basis for memory deficit, but Dr. Davis again explained that is contrary to medical fact and fails to follow the community standard for memory disorders. Dr. Davis concluded that Respondent engaged in an extreme departure from the standard of care by failing to state accurate medical facts on each patient's respective Form N-648.

40. Dr. Davis additionally considered the standard of care requiring physicians to keep complete medical records concerning their patients, including forms completed by office staff. Dr. Davis noted that Respondent's office failed to include in its production of medical records on January 21, 2015, and February 5, 2015, any copies of Form N-648 or its accompanying documents, such as MMSE results. At hearing, Dr. Davis explained that everything a physician does regarding a patient must be part of the medical record. As such, Dr. Davis concluded that unless Respondent's failure to include the immigration documents with the initial production of documents was rooted in fraud or deception, Respondent's actions represented a simple departure from the standard of care.

41. Dr. Davis' wealth of experience during more than 30 years of practice, teaching, and overseeing the family residency program at Dignity Medical Center, are positive factors in establishing Dr. Davis' credibility as an expert witness.[6]

42. Investigator Saeki, his superior, Supervising Investigator Jeffrey Gomez, who testified at hearing, and Dr. Jill Klessig, who serves as a medical consultant for the Board, conducted interviews of the patients on November 3, 2014, September 30, 2015, October 13, 2015, November 4, 2015, and November 30, 2015. According to

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[6] The manner and demeanor of a witness while testifying are the two most important factors a trier of fact considers when judging credibility. (See Evid. Code § 780.) The mannerisms, tone of voice, eye contact, facial expressions and body language are all considered, but are difficult to describe in such a way that the reader truly understands what causes the trier of fact to believe or disbelieve a witness. Evidence Code § 780 relates to credibility of a witness and states, in pertinent part, that a court "may consider in determining the credibility of a witness any matter that has any tendency in reason to prove or disprove the truthfulness of his testimony at hearing, including but not limited to any of the following: . . . (b) the character of his testimony; . . .(f) The existence or nonexistence of a bias, interest, or other motive; . . .(h) A statement made by him that is inconsistent with any part of his testimony at the hearing; (i) The existence or nonexistence of any fact testified to by him. . ."

The trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke Davis & Co.* (1973) 9 Cal.3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material." (*Id.*, at 67-68, quoting from *Neverov v. Caldwell* (1958) 161 Cal.App.2d 762, 767.) Further, the fact finder may reject the testimony of a witness, even an expert, although not contradicted. (*Foreman v. Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.) And the testimony of "one credible witness may constitute substantial evidence," including a single expert witness. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.) A fact finder may disbelieve any or all testimony of an impeached witness. (*Wallace v. Pacific Electric Ry. Co.* (1930) 105 Cal.App.664, 671.)

Supervising Investigator Gomez, Patients MA, NC, JL, CE, and EC, during the course of those interviews, stated that they did not undergo a MMSE or complete any questions appearing on the MMSE or any questions similar to those appearing on the MMSE, prior to the submission of Form N-648 prepared for each of them at Respondent's clinic.

43. Dr. Klessig, who testified at hearing, has owned a private genera l medical practice since 1982. She also serves as a professor at the David Geffen School of Medicine at UCLA, specifically in the Division of General Internal Medicine and Health Services Research. Dr. Klessig earned her bachelor's degree in psychobiology from UCLA in 1978 and her medical degree from UCLA's School of Medicine in 1982. She has earned lifetime board certifications from the American Board of Internal Medicine and from the National Board of Medical Examiners. Dr. Klessig has received a number of honors and awards throughout her career, including the Teacher of the Year Award on several occasions. She has also served as a guest lecturer on a number of topics related to internal medicines and has authored a number of peer-reviewed and non-peer-reviewed publications.

44. During the interviews of Patients EC, NC, JL, and AV, Dr. Klessig asked each of them questions found on the MMSE. Specifically, she asked them to identify a pen and explain its purpose; to remember the words "pen," "telephone, " and "soda," and then repeat the words when requested during the course of the interview; write a sentence on a piece of paper; pick up a sheet of paper, fold it in half, and then draw a copy of a picture on one half of the paper; and to state the current date. Each patient commented that they had not been asked to answer such questions during any visit to Respondent's clinic. In response to the questions posed by Dr. Klessig, each patient answered them appropriately and followed instructions well, including Patient AV, who was visibly ill when Dr. Klessig interviewed him.[7] Dr. Klessig concluded that none of the patients suffered a memory deficit as represented on their respective Form N-648, and that the MMSE results prepared by Respondent's office did not accurately reflect the patients' abilities.

45. The testimony of Supervising Investigator Gomez and Dr. Klessig are deemed credible, given the clear and straightforward manner in which they testified, without a hint of prevarication, and the consistency of their respective versions. Given these factors, the testimony of Supervising Investigator Gomez and Dr. Klessig are afforded significant weight.

46. Alicia Alarcon, who has known Respondent since 1999, testified at hearing. Ms. Alarcon has worked for the Spanish media for more than 25 years and

[7] Patient AV later died in 2015.

until a year ago, she served as a radio talk show host and a columnist for 10 newspapers. Currently, Ms. Alarcon is writing her third book.

47. As a radio talk show host, she talked about healthcare issues every day, and ventured out into the community to help supply her listening audience with information regarding healthcare. In that regard, Respondent served as a guest on her radio talk show on a number of occasions, educating Ms. Alarcon's audience about medical challenges such as diabetes and obesity, and also participated in weekly health fairs. Respondent served as Ms. Alarcon's sole sponsor at the radio station, and paid a talent fee to Ms. Alarcon. Respondent and Ms. Alarcon have worked together on a number of health campaigns, including campaigns addressing the prevention of venereal disease and teenage pregnancy.

48. Ms. Alarcon testified that before Respondent established clinics in Latino communities, individuals were forced to seek healthcare in hospital emergency rooms. Respondent's clinics provided specialty care for the community, such as cardiologists and neurologists.

49. Senators, congressmen, presidents, county supervisors, government offices, and others have honored Respondent with certificates of recognition for the work he has performed in underserved communities.

50. Petra Contreras wrote a character reference letter on Respondent's behalf and praised Respondent and his clinics for the friendly and efficient customer service and the good the clinics have provided to the community.

CONCLUSIONS OF LAW

Parties' Contentions

1. Complainant contends Respondent engaged in unprofessional conduct with respect to Patients CE, NC, EC, JL, MA, and AV. Specifically, Complainant asserts that Respondent engaged in acts of gross negligence, repeated negligent acts, false representations, and failed to maintain adequate and accurate medical records, stemming from Respondent's involvement in executing inaccurate and deceptive official documents directed to the DHS (i.e., multiple versions of Form N-648 and accompanying documentation , such as MMSE results). Complainant contends that by executing such documents, Respondent fraudulently certified that Patients CE, NC, EC, JL, MA, and AV were disabled for DHS purposes, and therefore should be exempted from having to satisfy the English language and/or civics requirements for obtaining citizenship.

2. Respondent, through his closing brief, presents his defense to the charges set forth in the Accusation, and asserts specific contentions. In short, with respect to allegations of general unprofessional conduct stemming from acts of gross negligence, repeated negligent acts, and false representations, Respondent asserts that he "relied upon his trusted physician assistant for almost ten years, [and he] should not be at risk of license revocation even if certain mistakes were made in a handful of forms." (Respondent's Closing Brief, page 4, lines 17-21.) Respondent also contends that he was as much of a victim of PA-LA's actions as the federal government was, asserting that PA-LA was arguably part of a larger fraudulent scheme, unbeknownst to Respondent, and that Complainant initiated disciplinary proceedings against PA-LA, accordingly. Respondent further contends that the claims set forth in the Accusation "depict a conspiracy in which the Complainant contends Respondent was a willing and active participant," which lacked any degree of specific intent on Respondent's part. (Respondent's Closing Brief, page 5, lines 6-10.) Respondent argues that Complainant provides no evidence that he had any idea that any one document contained false statements. Moreover, Respondent asserts Complainant provided no evidence that Respondent received any benefit whatsoever from the six patients.

3. With respect to allegations of failure to maintain adequate and accurate medical records, Respondent contends that Complainant failed to establish that Respondent deliberately withheld the patients' immigration documents (i.e., Form N-648 and its accompanying documents) when he produced medical records in response to Investigator Saeki's initial request. Respondent argues that Ms. Aguilar established that the immigration documentation was kept in a different location from the medical records, and that California law has no prohibition against such a practice. Finally, Respondent contends Complainant failed to meet her burden of establishing that his actions were deliberate and calculated to effectuate dysfunction.

The Applicable Law

4. The standard of proof which must be met to establish the charging allegations herein is "clear and convincing evidence." *(Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853.) This means the burden rests with Complainant to offer proof that is clear, explicit and unequivocal--so clear as to leave no substantial doubt and sufficiently strong to command the unhesitating assent of every reasonable mind. *(Katie V v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

5. The purpose of the Medical Practice Act[8] is to assure the high quality of medical practice; in other words, to keep unqualified and undesirable persons and those guilty of unprofessional conduct out of the medical profession. *(Shea v. Board of Medical Examiners* (1978) 81 Cal.App. 3d 564, 574.) The imposition of license discipline does not depend on whether patients were injured by unprofessional medical practices. (See, *Bryce v. Board of Medical Quality Assurance* (1986) 184 Cal.App.3d. 1471; *Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.) Our courts have long held that the purpose of physician discipline by the Board is not penal

[8] Business and Professions Code sections 2000 through 2521.

but to "protect the life, health and welfare of the people at large and to set up a plan whereby those who practice medicine will have the qualifications which will prevent, as far as possible, the evils which could result from ignorance or incompetency or a lack of honesty and integrity." *(Furnish v. Board of Medical Examiners* (1957) 149 Cal.App.2d 326, 331.

6. The law demands only that a physician or surgeon have the degree of learning and skill ordinarily possessed by practitioners of the medical profession in the same locality and that he exercise ordinary care in applying such learning and skill to the treatment of his patient. (Citations.) The same degree of responsibility is imposed in the making of a diagnosis as in the prescribing and administering of treatment. (Citations.) Ordinarily, a doctor's failure to possess or exercise the requisite learning or skill can be established only by the testimony of experts. (Citations.) Where, however, negligence on the part of a doctor is demonstrated by facts which can be evaluated by resort to common knowledge, expert testimony is not required since scientific enlightenment is not essential for the determination of an obvious fact. (Citations.) *(Lawless v. Calaway* (1944) 24 Cal.2d 81, 86.)

7. Business and Professions Code section 2234 states that the Board shall take action against any licensee who is charged with unprofessional conduct. Unprofessional conduct includes (b) gross negligence; (c) repeated negligent acts(two or more negligent acts); (d) incompetence; and (e) the commission of any act involving dishonesty which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

8. Gross negligence has been defined as an extreme departure from the ordinary standard of care or the "want of even scant care." *(Gore v. Board of Medical Quality Assurance* (1970) 110 Cal.App.3d 184, 195-198.)

9. A "negligent act" as used in [Business and Professions Code section 2234] is synonymous with the phrase, "simple departure from the standard of care." *(Zabetian v. Medical Board of California* (2000) 80 Cal.App.4th 462.)

10. Business and Professions Code section 2261 provides that "[k]nowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitute s unprofessional conduct."

11. Business and Professions Code section 2266 states that that "[t]he failure of a physician and surgeon to maintain adequate and accurate records relating to the provisions of services to their patients constitutes unprofessional conduct."

Analysis

12. Cause exists to discipline Respondent's certificate , pursuant to Business and Professions Code sections 2227, 2234, subdivisions (b) and (c), and 2261, for

unprofessional conduct rooted in gross negligence, repeated acts of negligence, and for making false representations, as set forth in Findings 3 through 50. Specifically, Complainant met her burden of establishing that Respondent engaged in multiple acts of gross negligence, repeated acts of negligence, and making false representations concerning all six patients, in that Respondent executed each Form N-648 that listed diagnoses that did not have supporting medical documentation contained within the patients' medical records, such as memory disorders, epilepsy, and genotype disorders, to name a few. Additionally, the forms contained medical assertions that did not follow the community standard and were contrary to medical fact. Specifically, one form stated that memory loss was a "progressive disease" while others stated that memory disorder was a disease that causes brain damage. Moreover, some forms contained an assertion that the presence of lipid genotypes served as a basis for memory deficit, even though such assertions were contrary to medical fact and failed to follow the community standard for memory disorders. Furthermore, according to the credible testimony of Supervising Investigator Gomez and Dr. Klessig, none of the patients they interviewed expressed that they had been exposed to the MMSE questions during the time they were treated at Respondent's clinic, casting suspicion, given the totality of the circumstances, on the MMSEs attached to the patients' respective Forms N-648. All of the above factors, as established by the credible testimony of Dr. Davis, establish extreme departures from the standard of care.

13. Respondent's position that he relied upon PA-LA for almost ten years, and that he was as much a victim of PA-LA's actions as the federal government was, is unpersuasive. His argument that Complainant presented no evidence that he had any idea that any document contained false statements is equally unpersuasive. Form N-648 was very clear in stating that all questions or items must be answered "fully and accurately" and that "only medical doctors, doctors of osteopathy, or clinical psychologists licensed to practice in the United States ... are authorized to certify the form." (Exhibit 6, page 1.) Additionally, Form N-648 stated that "[w]hile staff of the medical practice associated with the medical professional certifying the form may assist in its completion; the medical professional is responsible for the accuracy of the form's content." *(Id.)* Given the plain language of Form N-648, Respondent was solely responsible for ensuring the accuracy of the statements set forth in it, not PA-LA.

14. Cause exists to discipline Respondent's certificate , pursuant to Business and Professions Code sections 2227 and 2266, for his failure to maintain adequate records, as set forth in Findings 3 through 50. Specifically, Respondent repeatedly failed to accurately list information in patient's charts, particularly those he contended suffered memory deficits or disorders, substantiating the memory issues. Additionally, as noted by Dr. Davis, Respondent's office failed to include in its production of medical records on January 21, 2015 and February 5, 2015 any copies of Form N-648 or its accompanying documents (i.e., copies of MMSE results). These factors, according to Dr. Davis, represented a simple departure from the standard of care.

15. The purpose of a disciplinary action such as this one is to protect the public, and not to punish the licensee. *(Camacho v. Youde* (1979) 95 Cal.App.3d 161,

164; *Small v. Smith* (1971) 16 Cal.App.3d 450, 457.) Complainant seeks revocation. While the record does not establish Respondent's rationale for his apparent and repeated failure to pay close attention to his and his staff's actions, particularly when completing forms under penalty of perjury or maintaining accurate medical records, an appropriate level of discipline to remediate Respondent's conduct should include educational possibilities in connection with a significant period of probation, as opposed to revocation. Not only would such action protect the public, it is warranted in light of Respondent's blemish-free 38 year career, not to mention the lack of evidence demonstrating that Respondent benefitted financially or professionally from his actions.

16. In his written argument following non-adoption, Respondent suggested that at most a citation was warranted. In her argument, Complainant suggested that revocation of Respondent's license was warranted, and if revocation was not ordered, then a seven-year term of probation and a year suspension was justified.

The Panel believes that the level of discipline necessary to protect the public and aid in the rehabilitation of the licensee lies between those two points. Having reviewed the record and finding a lack of criminality and financial motivation in Respondent's actions, the Panel reduces the level of probation from five to three years and all other terms and conditions of probation remain unchanged.

ORDER

Certificate No. A 34248 issued to Respondent, Mahfouz Michael, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for three years, upon the following terms and conditions:

1. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. **Medical Record Keeping Course**

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee.

Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. **Professionalism Program (Ethics Course)**

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of California Code of Regulations, title 16 (CCR), section 1358. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. **Monitoring – Practice**

Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quailerly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved andassumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term ofprobation.

5. **Notification**

Within seven days of the effective date of this Decis1on, Respondent shall provide a true and correct copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

6. **Supervision of Physician Assistants**

During probation, Respondent is prohibited from supervising physician assistants.

7. **Obey All Laws**

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

8. **Quarterly Declarations**

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

9. **General Probation Requirements**

Compliance with Probation Unit:

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes:

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice:

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal:

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California:

Respondent shall immediately inform the Board or its designee, in writing, of travel to

any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

10. **Interview with the Board or its Designee**

Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

11. **Non-practice While on Probation**

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice las ting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

12. **Violation of Probation**

Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

13. **License Surrender**

Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall, within 15 calendar days, deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

14. **Probation Monitoring Costs**

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

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15. **Completion of Probation**

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

The Decision shall become effective at 5:00 p.m. on **March 7, 2018**.

IT IS SO ORDERED this **5th** day of **February** 2018.

Kristina D. Lawson, J.D., Chair
Panel B
Medical Board of California

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
	)	
MAHFOUZ M. MICHAEL, M.D.	)	
	)	Case No.: 800-2014-008113
Physician's & Surgeon's	)	
Certificate No: A34248	)	OAH No.: 2017020730
	)	
Respondent	)	
	)	
	)	

ORDER OF NON-ADOPTION OF PROPOSED DECISION

The Proposed Decision of the Administrative Law Judge in the above-entitled matter has been **non-adopted.** A panel of the Medical Board of California (Board) will decide the case upon the record, including the transcript and exhibits of the hearing, and upon such written argument as the parties may wish to submit directed at whether the level of discipline ordered is sufficient to protect the public. The parties will be notified of the date for submission of such argument when the transcript of the above-mentioned hearing becomes available.

To order a copy of the transcript, please contact Jilio-Ryan Court Reporters, 14661 Franklin Ave., Suite 150, Tustin, CA 92780. The telephone number is (800) 454-1230

To order a copy of the exhibits, please submit a written request to this Board.

In addition, oral argument will only be scheduled if a party files a request for oral argument with the Board within 20 days from the date of this notice. If a timely request is filed, the Board will serve all parties with written notice of the time, date and place for oral argument. Oral argument shall be directed only to the question of whether the proposed penalty should be modified. Please do not attach to your written argument any documents that are not part of the record as they cannot be considered by the Panel. The Board directs the parties attention to Title 16 of the California Code of Regulations, sections 1364.30 and 1364.32 for additional requirements regarding the submission of oral and written argument.

Please remember to serve the opposing party with a copy of your written argument and any other papers you might file with the Board. The mailing address of the Board is as follows:

MEDICAL BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-3831
(916) 263-8906
Attention: Richard M. Acosta

Date: November 6, 2017

Kristina Lawson

Kristina Lawson, JD, Chair
Panel B

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: MAHFOUZ MICHAEL, M.D., Physician's and Surgeon's Certificate Number A34248, Respondent.	Case No. 800-2014-008113 OAH No. 2017020730

PROPOSED DECISION

Administrative Law Judge (ALJ) Carla L. Garrett heard this matter on August 14, 15, 16, and 17, 2017, at Los Angeles, California.

Beneth A. Browne, Deputy Attorney General, represented Complainant Kimberly Kirchmeyer (Complainant), Executive Director of the Medical Board of California (Board). Craig B. Garner, Attorney at Law, represented Mahfouz Michael, M.D. (Respondent), who was present at the hearing.

During the hearing, Complainant's motion to amend the Accusation was granted, as follows: on page 4, paragraph 11, line 14, "54" is changed to "55"; on page 5, paragraph 13, line 5, "19/30" is changed to "20/30"; and on page 7, paragraph 22, line 15, "the same date" is changed to "April 23, 2014."

On August 16, 2017, Respondent moved for a protective order requesting that all exhibits, transcripts, recordings, and other documents filed with OAH in connection with the above-referenced matter, be placed under seal because the documents contain confidential information which is protected from disclosure to the public. Redaction of the documents to obscure this information was not practicable and would not have provided adequate privacy protection. Complainant did not oppose the motion. In order to protect the privacy of the various individuals identified in the documents and to prevent the disclosure of confidential information, the ALJ issued a Protective Order placing the following under seal after their use in preparation of this Decision: all exhibits, except jurisdictional documents (Exhibits 1 through 3), written factual stipulations (Exhibit 48), the protective order request (Exhibit 49), and witness names on confidential names list contained in the record. Those documents shall remain under seal and shall not be opened, except as provided by the Protective Order. A

reviewing court, parties to this matter, their attorneys, and a government agency decision maker or designee under Government Code section 11517 may review the documents subject to the Protective Order provided that such documents are protected from release to the public.

Oral and documentary evidence was received. The record remained open to give Respondent an opportunity to submit a written closing brief by August 25, 2017, and to give Complainant an opportunity to file a written rebuttal brief by September 1, 2017.[1] Respondent and Complainant submitted timely closing and rebuttal briefs, respectively. The record was closed on September 1, 2017, and the matter was submitted for decision.

FINDINGS OF FACT[2]

1. Complainant made the Accusation in her official capacity as Executive Director of the Board, alleging that Respondent had engaged in acts of gross negligence, repeated negligent acts, false representations, inadequate and inaccurate medical records, and general unprofessional conduct.

2. The Board issued Physician's and Surgeon's Certificate Number A34248 to Respondent on August 3, 1979. The certificate is scheduled to expire on March 31, 2019. Respondent has enjoyed a blemish-free 38 year career.

3. On July 9, 2014, the Board received a complaint alleging Respondent had engaged in fraudulent activities regarding six patients (Patients CE[3], NC, EC, JL, MA, and AV) in connection with his execution of Medical Certification for Disability Exceptions forms, also known as Form N-648, submitted to the Department of Homeland Security (DHS) on their behalf. Form N-648 is used to provide evidence to DHS that an applicant for citizenship has a physical or developmental disability or mental impairment that has lasted, or is expected to last, 12 months or more, that prevents him or her, even if provided a reasonable accommodation, from satisfying the English language and/or civics requirements. Form N-648 requires that all questions or items be answered "fully and accurately" and that "only medical doctors, doctors of osteopathy, or clinical psychologists licensed to practice in the United States . . . are authorized to certify the form." (Exhibit 6, page 1.) Finally, Form N-648 provides that "[w]hile staff of the medical practice associated with the medical

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[1] Complainant presented an oral closing argument on the final day of the hearing.

[2] The Factual Findings represent findings reached by the ALJ combined with factual stipulations set forth in Exhibit 48.

[3] Patients are identified by their initials to protect their privacy.

professional certifying the form may assist in its completion; the medical professional is responsible for the accuracy of the form's content." (*Id.*)

4. On December 30, 2014, Investigator Gregory Saeki of the Health and Quality Investigation Unit of the Division of Investigation, visited Respondent's clinic (San Miguel Medical Center) and issued compliancy letters requesting medical records of the subject patients, medical releases signed by the subject patients, and certification of records forms.

5. On January 21, 2015, in response to Investigator Saeki's requests for medical records, Respondent's office submitted the medical records of Patients CE (9 pages), NC (131 pages), JL (70 pages), MA (143 pages), and AV (203 pages). On February 5, 2015, Respondent's office submitted the medical records of Patient EC (70 pages). With the submission of the medical records, Respondent's office manager, Connie Aguilar, executed a Certification of Records form for each patient declaring under penalty of perjury that the submitted records were "complete records" and were "prepared and maintained in the ordinary course of business . . . at or near the time of the acts, conditions or events described by such records." (Exhibits 24-29.) None of the medical records submitted on January 21, 2015 or February 5, 2015, included any copies of Form N-648 or its accompanying documents, such as copies of mini mental state examination (MMSE) results.[4]

6. On April 15, 2015, Respondent's office submitted additional medical records of Patients CE (7 pages), NC (7 pages), EC (7 pages), JL (7 pages), MA (22 pages), and AV (21 pages). The medical records included a Form N-648 and MMSE results for each of these patients.

7. Ms. Aguilar testified at hearing and explained that in response to the request for the patients' medical records; she printed them from the office's electronic medical records (EMR) computer system. Ms. Aguilar further explained that she did not include immigration documentation (i.e., Form N-648 and accompanying documents) with the initial document production because they were stored in a separate file in a separate cabinet. When Respondent's office discovered it had not included the immigration documents with the initial production, Respondent's office provided them on April 15, 2015.

Patient CE

8. On April 10, 2014, Patient CE, a Spanish-speaking 55-year-old female patient, presented at Respondent's clinic complaining of shoulder pain. Respondent's Physician's Assistant LA[5] (PA-LA) met with Patient CE and noted in Patient CE's medical chart the following: "rt shoulder pain x 3 weeks, since after fall, pt is experiencing memory deficit, pt does not read, speak neither write English." PA-LA did not include any further details regarding Patient CE's history. Under the "assessment" section of the medical notes,

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[4] MMSE results and their import are discussed in more detail below.

[5] This Physician's Assistant is identified by initials to protect his privacy.

PA-LA stated "memory deficit, hypertension, gastritis, and osteoarthritis as well as right shoulder pain," but provided no details to document that he had performed a physical examination and evaluation of the right shoulder, or to substantiate that Patient CE had "memory deficit." Under the "plan" section of the medical notes, PA-LA stated "refer to neurologist, mini mental state exam [MMSE]," and various lifestyle recommendations."

9. On April 17, 2017, Patient CE returned to Respondent's clinic for a follow-up visit. The medical notes corresponding to Patient CE's visit indicate that Patient CE had gone to school in Guatemala up to the second grade, and note that Patient CE could not read, write, or speak English. Additionally, the medical notes state that Patient CE was attending school but was unable to retain new information or concepts. The medical notes also state in the "assessment section" the following: "normal routine history and physical, normal routine history and physical adult, essential hypertension, obesity and memory deficit." The medical notes reflected no diagnosis or reason for the "memory deficit" cited.

10. Patient CE's medical records note that Patient CE underwent a MMSE administered on April 23, 2014, which revealed a score of 20 out of 30, indicating severe impairment.

11. On April 23, 2014, PA-LA completed a Form N-648 for Patient CE. PA-LA listed the reasons for Patient CE's disability as memory deficit, hypertension, osteoarthritis, obesity and gastritis. PA-LA noted on the form that Patient CE's MMSE score was 20 out of 30, and listed genotype disorders as an etiology of memory deficit. PA-LA further stated on Form N-648 that:

> "[Memory loss is a] progressive disease that may cause cerebral function to diminish and it is always irreversible. It can be partial or complete or it can produce concentration deficit. The loss of memory can be caused by psychological factors, post-traumatic stress, or after experiencing highly stressing events."

(Exhibit 6, page 8.)

12. PA-LA also stated on Form N-648 that Patient CE required assistance with basic daily needs of life, such as cooking, shopping, and transportation, even though Patient CE's medical chart included no documentation of such. Additionally, PA-LA noted on Form N-648 that Patient had epilepsy, but such a diagnosis was not mentioned in Patient CE's medical records.

13. After PA-LA completed Form N-648, Respondent signed it under penalty of perjury, certifying that Patient CE was disabled for DHS purposes, and therefore should be exempted from having to satisfy the English language and/or civics requirements for obtaining citizenship.

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Patient NC

14. On December 14, 2010, Patient NC presented to Respondent's clinic to address diabetes and hypertension. PA-LA treated Patient NC on October 7, 2011 and June 12, 2012. On March 1, 2013, a different physician's assistant met with Patient NC and noted in Patient NC's chart, "Memory unimpaired in nml conversation." PA-LA saw Patient NC on April 1, 2013, October 17, 2013, and January 22, 2014.

15. Patient NC's medical records indicate that Patient NC underwent a MMSE administered on April 23, 2014, which revealed a score of 19 out of 30, indicating severe impairment.

16. On April 23, 2014, Respondent signed Form N-648, under penalty of perjury, certifying that Patient NC was disabled for DHS purposes, and therefore should be exempted from having to satisfy the English language and/or civics requirements for obtaining citizenship. The form stated that Patient NC had a memory disorder and that the memory disorder itself was a disease that causes brain damage. However, Patient NC's medical chart mentions nothing about a memory disorder. Additionally, the form states that Patient NC suffers from anxiety that limits Patient NC's ability to learn, even though such anxiety is not documented in Patient NC's chart. The form additionally states that Patient NC was referred to a neurologist, but the purported referral is not documented in Patient NC's chart. Moreover, the form states that Patient NC's MMSE score was 20 out of 30.

Patient EC

17. On January 27, 2012, Patient EC presented at Respondent's clinic with diabetes, hypertension, and osteoarthritis, and was treated at Respondent's clinic on multiple occasions.

18. On February 17, 2013, Patient EC complained of tremors, prompting Respondent's clinic to refer Patient EC to a neurologist to rule out Parkinson's disease. Patient EC's chart does not document whether Patient EC visited a neurologist or whether Patient EC's issue with tremors had been addressed.

19. On April 6, 2014, Patient EC presented at Respondent's clinic with abdominal pain. PA-LA treated Patient EC, failed to chart his diagnosis regarding Patient EC's abdominal pain, but prescribed an antibiotic (Flagyl).

20. On April 23, 2014, Respondent signed Form N-648, under penalty of perjury, certifying that Patient EC was disabled for DHS purposes, and therefore should be exempted from having to satisfy the English language and/or civics requirements for obtaining citizenship. The form states that Patient EC suffered a memory disability and lists diagnoses of epilepsy, memory deficit, and genotype disorders, even though those diagnoses are not reflected in Patient EC's chart. Additionally, the form notes that Patient EC's MMSE score was 20 out of 30.

Patient JL

21. On February 26, 2013, Patient JL presented at Respondent's clinic with diabetes, hypertension, and osteoarthritis, and was treated at Respondent's clinic on multiple occasions.

22. On April 22, 2014, a physician other than Respondent treated Patient JL at Respondent's clinic, and performed a mammogram and a pap smear. Respondent signed Form N-648, under penalty of perjury, certifying that Patient JL was disabled for DHS purposes, and therefore should be exempted from having to satisfy the English language and/or civics requirements for obtaining citizenship. The form states Patient JL suffered a memory disability and listed diagnoses of epilepsy, memory deficit, and genotype disorders, even though those diagnoses were not reflected in Patient JL's chart. The form indicates that Patient JL had a memory disorder and that that memory disorder itself was a disease that causes brain damage. The form additionally notes that Patient JL's MMSE score was 20 out of 30, although the results of the MMSE purportedly taken by Patient JL, as produced pursuant to the records demand described in Factual Findings 4 through 6, revealed results of 19 out of 30.

Patient MA

23. On June 11, 2012, Patient MA, a 66 year-old woman, first presented at Respondent's clinic and was diagnosed with hypertension, obesity, and bradycardia. Respondent treated at Respondent's clinic on multiple occasions, and had a normal neurological exam noted at many visits. Patient MA was subsequently diagnosed with diabetes.

24. On June 17, 2012, PA-LA treated Patient MA for a cough. PA-LA noted in Patient MA's chart that Patient MA was "unable to learn questionary (*sic*) for U.S. citizenship." PA-LA noted in Patient MA's chart that Patient MA suffered a memory deficit, but listed no history or examination in Patient MA's chart regarding memory issues.

25. On August 14, 2013, PA-LA treated Patient MA for a cough, lower back pain, and a foot condition. PA-LA noted in Patient MA's chart that Patient MA was "unable to learn questionary (*sic*) for U.S. citizenship interview." PA-LA noted in Patient MA's chart that Patient MA suffered a memory deficit, but listed no history or examination in Patient MA's chart regarding memory issues. PA-LA noted a plan to refer Patient MA a neurologist and perform a MMSE.

26. On September 10, 2013, PA-LA treated Patient MA when she came to Respondent's clinic for a medical visit. PA-LA noted in Patient MA's chart that Patient MA was "unable to learn questionary (*sic*) for U.S. citizenship." PA-LA noted that Patient MA could not read or write in English or Spanish and had a hearing deficit, and noted a plan to perform a MMSE.

27. On April 8, 2014, PA-LA treated Patient MA when she came to Respondent's clinic for a medical visit. PA-LA included additional history in Patient MA's chart. Specifically, PA-LA noted that Patient MA suffered a head injury and a hearing deficit, attended school to the sixth grade, and was occasionally forgetful. PA-LA diagnosed Patient MA with mild memory disturbance following organic brain damage, and noted a plan to perform a MMSE.

28. On April 14, 2014, Respondent signed Form N-648, under penalty of perjury, certifying that Patient MA was disabled for DHS purposes, and therefore should be exempted from having to satisfy the English language and/or civics requirements for obtaining citizenship. The form states that Patient MA suffered a memory deficit, had a history of head trauma, hypertension, diabetes, osteoarthritis, incontinence, and suffered a hearing deficit. The form ascribes Patient MA's disability to psychological factors or to post traumatic experience due to head trauma, and states the memory deficit was due to amyloid plaques as well as "lipoprotein E episilon 4 genotype." (Exhibit 6, page4.) Patient MA's medical chart references no presence of amyloid plaques or lipoprotein E episilon 4 genotype. The form also states that Patient MA's memory disorder itself was a disease that causes brain damage. The form additionally states that Patient MA underwent a MMSE which revealed a score of 20 out of 30.

29. Patient MA, who testified at hearing, denied suffering a memory deficit or disorder. In fact, at the time the form was completed, Patient MA had been caring for her husband on a daily basis, because he had been rendered disabled as a result of a stroke. As his caretaker, Patient MA regularly bathed her husband, cooked for him, and helped to dress him, among other things.

30. Patient MA paid "Eddie" of Respondent's office $300 for ensuring Form N-648 was completed on her behalf, but subsequently demanded a return of her money, because the form submitted to immigration was rejected, as it was not completed properly. For example, the form stated, in essence, that she was forgetful, which prompted immigration officers to ask Patient MA how she was able to cook and care for her husband everyday if she was supposedly forgetful.

31. Patient MA denied that she was forgetful. Patient MA also denied suffering from post-traumatic stress as represented on the form. While she concedes she suffered a head injury when she fell out of a tree when she was 13 years old, the only long-term medical issue stemming from her fall was a hearing deficit.

32. On September 22, 2014, Patient MA received treatment from a different physician in Respondent's clinic to address Patient MA's chief complaint of back pain. The physician documented a comprehensive examination, including a review of Patient MA's neurological status, in which the physician noted no neurological concerns or issues. Additionally, the physician mentioned nothing about memory issues or abnormalities, and documented a normal MMSE.

Patient AV

33. On December 30, 2013, Patient AV presented at Respondent's clinic and met with PA-LA. Patient AV had a history of moderately differentiated adenocarcinoma of the colon, and had been previously diagnosed with hypertension, osteoarthritis, and diabetes. Patient AV had low anterior resection surgery with colostomy placement. PA-LA performed a medication review.

34. On April 10, 2014, PA-LA met with Patient AV in follow up to an emergency room visit Patient AV experienced when he suffered abdominal pain. At the time of the office visit, Patient AV was in pain and on narcotic pain medications. PA-LA referred Patient AV to his oncologist. PA-LA made no neurology referral for Patient AV.

35. On April 10, 2014, Respondent signed Form N-648, under penalty of perjury, certifying that Patient AV was disabled for DHS purposes, and therefore should be exempted from having to satisfy the English language and/or civics requirements for obtaining citizenship. The form listed the reasons for Patient AV's disability as memory deficits, cancer, diabetes, hypertension, asthma, osteoarthritis, and anxiety. The form also cited lipid genotypes as a basis for Patient AV's memory deficit and asserted that diabetes and hypertension caused memory loss. The form listed an MMSE score of 20 out of 30, but no such test was documented in Patient AV's chart.

Expert Testimony

36. Pamela M. Davis, M.D., provided expert testimony on behalf of the Board. Dr. Davis, who has been a Board consultant since the 1990's, earned her bachelor's degree in microbiology from the University of California at Los Angeles (UCLA) in 1978, and her medical degree from UCLA School of Medicine in 1982. She completed her residency at Northridge Family Medicine Residency Program in 1985. Thereafter, Dr. Davis served as a Clinical Instructor, Associate Director, and Acting Director at Northridge Hospital Medical Center, and has served in her current position since 2001 as the Director of Residency at Dignity Medical Center at Northridge Hospital Family Medicine Residency Program. As the Director of Residency, Dr. Davis controls and directs the curriculum of the residents, which includes reviewing medical records.

37. On June 25, 2015, the Board requested that Dr. Davis review the medical records of Patients CE, NC, EC, JL, MA, and AV.

38. With respect to Patients CE, EC, and JL, after reviewing their respective medical records, Dr. Davis considered the standard of care for physicians that requires them to make truthful representations of history, physical diagnoses, and impressions regarding a patient. In that regard, Dr. Davis noted that Respondent signed a Form N-648 for Patients CE, EC, and JL that listed diagnoses, such as epilepsy and genotype disorders, that did not have any supporting medical documentation in their respective records. Similarly, with respect to Patients NC, MA, and AV, Respondent signed forms that listed memory disorder

as a diagnosis, but no supporting medical documentation existed in the patients' respective medical records. Given these factors, Dr. Davis concluded that Respondent engaged in an extreme departure from the standard of care by failing to provide honest and reliable information as required.

39. Dr. Davis also considered the standard of care requiring physicians to be informed and up to date as to current medical knowledge and the current practice of medicine, particularly in areas of medicine that the physician uses in practice. Dr. Davis noted that Respondent made medical assertions that did not follow the community standard in memory disorders with respect to Patient CE. Specifically, Respondent signed Patient CE's Form N-648 which asserted that memory loss was a "progressive disease," which is contrary to medical fact. Dr. Davis explained that memory loss is not a disease, but rather is a symptom. Similarly, with respect to Patients NC, JL, and MA, Respondent signed Patients NC's, JL's, and MA's Form N-648 which asserted that memory disorder was a disease that causes brain damage. Dr. Davis explained that such assertions were contrary to medical fact, and they do not follow the community standard for memory disorders. Additionally, with respect to Patients MA and AV, the form states that the presence of lipid genotypes serves as a basis for memory deficit, but Dr. Davis again explained that is contrary to medical fact and fails to follow the community standard for memory disorders. Dr. Davis concluded that Respondent engaged in an extreme departure from the standard of care by failing to state accurate medical facts on each patient's respective Form N-648.

40. Dr. Davis additionally considered the standard of care requiring physicians to keep complete medical records concerning their patients, including forms completed by office staff. Dr. Davis noted that Respondent's office failed to include in its production of medical records on January 21, 2015, and February 5, 2015, any copies of Form N-648 or its accompanying documents, such as MMSE results. At hearing, Dr. Davis explained that everything a physician does regarding a patient must be part of the medical record. As such, Dr. Davis concluded that unless Respondent's failure to include the immigration documents with the initial production of documents was rooted in fraud or deception, Respondent's actions represented a simple departure from the standard of care.

41. Dr. Davis' wealth of experience during more than 30 years of practice, teaching, and overseeing the family residency program at Dignity Medical Center, are positive factors in establishing Dr. Davis' credibility as an expert witness.[6] Dr. Davis

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[6] The manner and demeanor of a witness while testifying are the two most important factors a trier of fact considers when judging credibility. (See Evid. Code § 780.) The mannerisms, tone of voice, eye contact, facial expressions and body language are all considered, but are difficult to describe in such a way that the reader truly understands what causes the trier of fact to believe or disbelieve a witness.

Evidence Code section 780 relates to credibility of a witness and states, in pertinent part, that a court "may consider in determining the credibility of a witness any matter that has

testified in a clear and straightforward manner, and her opinions were reasonable and not controverted by contradictory expert testimony. Given these factors, Dr. Davis' conclusions and expert opinion are afforded significant weight.

Investigation Interviews of Patients

42. Investigator Saeki, his superior, Supervising Investigator Jeffrey Gomez, who testified at hearing, and Dr. Jill Klessig, who serves as a medical consultant for the Board, conducted interviews of the patients on November 3, 2014, September 30, 2015, October 13, 2015, November 4, 2015, and November 30, 2015. According to Supervising Investigator Gomez, Patients MA, NC, JL, CE, and EC, during the course of those interviews, stated that they did not undergo a MMSE or complete any questions appearing on the MMSE or any questions similar to those appearing on the MMSE, prior to the submission of Form N-648 prepared for each of them at Respondent's clinic.

43. Dr. Klessig, who testified at hearing, has owned a private general medical practice since 1982. She also serves as a professor at the David Geffen School of Medicine at UCLA, specifically in the Division of General Internal Medicine and Health Services Research. Dr. Klessig earned her bachelor's degree in psychobiology from UCLA in 1978 and her medical degree from UCLA's School of Medicine in 1982. She has earned lifetime board certifications from the American Board of Internal Medicine and from the National Board of Medical Examiners. Dr. Klessig has received a number of honors and awards throughout her career, including the Teacher of the Year Award on several occasions. She has also served as a guest lecturer on a number of topics related to internal medicines and has authored a number of peer-reviewed and non-peer-reviewed publications.

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any tendency in reason to prove or disprove the truthfulness of his testimony at the hearing, including but not limited to any of the following: . . . (b) The character of his testimony; . . . (f) The existence or nonexistence of a bias, interest, or other motive; . . . (h) A statement made by him that is inconsistent with any part of his testimony at the hearing; (i) The existence or nonexistence of any fact testified to by him. . . ."

The trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke Davis & Co.* (1973) 9 Cal.3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material." (*Id.*, at 67-68, quoting from *Neverov v. Caldwell* (1958) 161 Cal.App.2d 762, 767.) Further, the fact finder may reject the testimony of a witness, even an expert, although not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.) And the testimony of "one credible witness may constitute substantial evidence," including a single expert witness. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.) A fact finder may disbelieve any or all testimony of an impeached witness. (*Wallace v. Pacific Electric Ry. Co.* (1930) 105 Cal.App. 664, 671.)

44. During the interviews of Patients EC, NC, JL, and AV, Dr. Klessig asked each of them questions found on the MMSE. Specifically, she asked them to identify a pen and explain its purpose; to remember the words "pen," "telephone," and "soda," and then repeat the words when requested during the course of the interview; write a sentence on a piece of paper; pick up a sheet of paper, fold it in half, and then draw a copy of a picture on one half of the paper; and to state the current date. Each patient commented that they had not been asked to answer such questions during any visit to Respondent's clinic. In response to the questions posed by Dr. Klessig, each patient answered them appropriately and followed instructions well, including Patient AV, who was visibly ill when Dr. Klessig interviewed him.[7] Dr. Klessig concluded that none of the patients suffered a memory deficit as represented on their respective Form N-648, and that the MMSE results prepared by Respondent's office did not accurately reflect the patients' abilities.

45. The testimony of Supervising Investigator Gomez and Dr. Klessig are deemed credible, given the clear and straightforward manner in which they testified, without a hint of prevarication, and the consistency of their respective versions. Given these factors, the testimony of Supervising Investigator Gomez and Dr. Klessig are afforded significant weight.

Character Testimony

46. Alicia Alarcon, who has known Respondent since 1999, testified at hearing. Ms. Alarcon has worked for the Spanish media for more than 25 years and until a year ago, she served as a radio talk show host and a columnist for 10 newspapers. Currently, Ms. Alarcon is writing her third book.

47. As a radio talk show host, she talked about healthcare issues every day, and ventured out into the community to help supply her listening audience with information regarding healthcare. In that regard, Respondent served as a guest on her radio talk show on a number of occasions, educating Ms. Alarcon's audience about medical challenges such as diabetes and obesity, and also participated in weekly health fairs. Respondent served as Ms. Alarcon's sole sponsor at the radio station, and paid a talent fee to Ms. Alarcon. Respondent and Ms. Alarcon have worked together on a number of health campaigns, including campaigns addressing the prevention of venereal disease and teenage pregnancy.

48. Ms. Alarcon testified that before Respondent established clinics in Latino communities, individuals were forced to seek healthcare in hospital emergency rooms. Respondent's clinics provided specialty care for the community, such as cardiologists and neurologists.

49. Senators, congressmen, presidents, county supervisors, government offices, and others have honored Respondent with certificates of recognition for the work he has performed in underserved communities.

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[7] Patient AV later died in 2015.

50. Petra Contreras wrote a character reference letter on Respondent's behalf and praised Respondent and his clinics for the friendly and efficient customer service and the good the clinics have provided to the community.

CONCLUSIONS OF LAW

Parties' Contentions

1. Complainant contends Respondent engaged in unprofessional conduct with respect to Patients CE, NC, EC, JL, MA, and AV. Specifically, Complainant asserts that Respondent engaged in acts of gross negligence, repeated negligent acts, false representations, and failed to maintain adequate and accurate medical records, stemming from Respondent's involvement in executing inaccurate and deceptive official documents directed to the DHS (i.e., multiple versions of Form N-648 and accompanying documentation, such as MMSE results). Complainant contends that by executing such documents, Respondent fraudulently certified that Patients CE, NC, EC, JL, MA, and AV were disabled for DHS purposes, and therefore should be exempted from having to satisfy the English language and/or civics requirements for obtaining citizenship.

2. Respondent, through his closing brief, presents his defense to the charges set forth in the Accusation, and asserts specific contentions. In short, with respect to allegations of general unprofessional conduct stemming from acts of gross negligence, repeated negligent acts, and false representations, Respondent asserts that he "relied upon his trusted physician assistant for almost ten years, [and he] should not be at risk of license revocation even if certain mistakes were made in a handful of forms." (Respondent's Closing Brief, page 4, lines 17-21.) Respondent also contends that he was as much of a victim of PA-LA's actions as the federal government was, asserting that PA-LA was arguably part of a larger fraudulent scheme, unbeknownst to Respondent, and that Complainant initiated disciplinary proceedings against PA-LA, accordingly. Respondent further contends that the claims set forth in the Accusation "depict a conspiracy in which the Complainant contends Respondent was a willing and active participant," which lacked any degree of specific intent on Respondent's part. (Respondent's Closing Brief, page 5, lines 6-10.) Respondent argues that Complainant provides no evidence that he had any idea that any one document contained false statements. Moreover, Respondent asserts Complainant provided no evidence that Respondent received any benefit whatsoever from the six patients.

3. With respect to allegations of failure to maintain adequate and accurate medical records, Respondent contends that Complainant failed to establish that Respondent deliberately withheld the patients' immigration documents (i.e., Form N-648 and its accompanying documents) when he produced medical records in response to Investigator Saeki's initial request. Respondent argues that Ms. Aguilar established that the immigration documentation was kept in a different location from the medical records, and that California law has no prohibition against such a practice. Finally, Respondent contends Complainant

failed to meet her burden of establishing that his actions were deliberate and calculated to effectuate dysfunction.

The Applicable Law

4. The standard of proof which must be met to establish the charging allegations herein is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853.) This means the burden rests with Complainant to offer proof that is clear, explicit and unequivocal--so clear as to leave no substantial doubt and sufficiently strong to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

5. The purpose of the Medical Practice Act[8] is to assure the high quality of medical practice; in other words, to keep unqualified and undesirable persons and those guilty of unprofessional conduct out of the medical profession. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App. 3d 564, 574.) The imposition of license discipline does not depend on whether patients were injured by unprofessional medical practices. (See, *Bryce v. Board of Medical Quality Assurance* (1986) 184 Cal.App.3d. 1471; *Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.) Our courts have long held that the purpose of physician discipline by the Board is not penal but to "protect the life, health and welfare of the people at large and to set up a plan whereby those who practice medicine will have the qualifications which will prevent, as far as possible, the evils which could result from ignorance or incompetency or a lack of honesty and integrity." (*Furnish v. Board of Medical Examiners* (1957) 149 Cal.App.2d 326, 331.

6. The law demands only that a physician or surgeon have the degree of learning and skill ordinarily possessed by practitioners of the medical profession in the same locality and that he exercise ordinary care in applying such learning and skill to the treatment of his patient. (Citations.) The same degree of responsibility is imposed in the making of a diagnosis as in the prescribing and administering of treatment. (Citations.) Ordinarily, a doctor's failure to possess or exercise the requisite learning or skill can be established only by the testimony of experts. (Citations.) Where, however, negligence on the part of a doctor is demonstrated by facts which can be evaluated by resort to common knowledge, expert testimony is not required since scientific enlightenment is not essential for the determination of an obvious fact. (Citations.) (*Lawless v. Calaway* (1944) 24 Cal.2d 81, 86.)

7. Business and Professions Code section 2234 states that the Board shall take action against any licensee who is charged with unprofessional conduct. Unprofessional conduct includes (b) gross negligence; (c) repeated negligent acts

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[8] Business and Professions Code sections 2000 through 2521.

(two or more negligent acts); (d) incompetence; and (e) the commission of any act involving dishonesty which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

8. Gross negligence has been defined as an extreme departure from the ordinary standard of care or the "want of even scant care." (*Gore v. Board of Medical Quality Assurance* (1970) 110 Cal.App.3d 184, 195-198.)

9. A "negligent act" as used in [Business and Professions Code section 2234] is synonymous with the phrase, "simple departure from the standard of care." (*Zabetian v. Medical Board of California* (2000) 80 Cal.App.4th 462.)

10. Business and Professions Code section 2261 provides that "[k]nowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct."

11. Business and Professions Code section 2266 states that that "[t]he failure of a physician and surgeon to maintain adequate and accurate records relating to the provisions of services to their patients constitutes unprofessional conduct."

Analysis

12. Cause exists to discipline Respondent's certificate, pursuant to Business and Professions Code sections 2227, 2234, subdivisions (b) and (c), and 2261, for unprofessional conduct rooted in gross negligence, repeated acts of negligence, and for making false representations, as set forth in Findings 3 through 50. Specifically, Complainant met her burden of establishing that Respondent engaged in multiple acts of gross negligence, repeated acts of negligence, and making false representations concerning all six patients, in that Respondent executed each Form N-648 that listed diagnoses that did not have supporting medical documentation contained within the patients' medical records, such as memory disorders, epilepsy, and genotype disorders, to name a few. Additionally, the forms contained medical assertions that did not follow the community standard and were contrary to medical fact. Specifically, one form stated that memory loss was a "progressive disease" while others stated that memory disorder was a disease that causes brain damage. Moreover, some forms contained an assertion that the presence of lipid genotypes served as a basis for memory deficit, even though such assertions were contrary to medical fact and failed to follow the community standard for memory disorders. Furthermore, according to the credible testimony of Supervising Investigator Gomez and Dr. Klessig, none of the patients they interviewed expressed that they had been exposed to the MMSE questions during the time they were treated at Respondent's clinic, casting suspicion, given the totality of the circumstances, on the MMSEs attached to the patients' respective Forms N-648. All of the above factors, as established by the credible testimony of Dr. Davis, establish extreme departures from the standard of care.

13. Respondent's position that he relied upon PA-LA for almost ten years, and that he was as much a victim of PA-LA's actions as the federal government was, is unpersuasive. His argument that Complainant presented no evidence that he had any idea that any document contained false statements is equally unpersuasive. Form N-648 was very clear in stating that all questions or items must be answered "fully and accurately" and that "only medical doctors, doctors of osteopathy, or clinical psychologists licensed to practice in the United States . . . are authorized to certify the form." (Exhibit 6, page 1.) Additionally, Form N-648 stated that "[w]hile staff of the medical practice associated with the medical professional certifying the form may assist in its completion; the medical professional is responsible for the accuracy of the form's content." (*Id.*) Given the plain language of Form N-648, Respondent was solely responsible for ensuring the accuracy of the statements set forth in it, not PA-LA.

14. Cause exists to discipline Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2266, for his failure to maintain adequate records, as set forth in Findings 3 through 50. Specifically, Respondent repeatedly failed to accurately list information in patients' charts, particularly those he contended suffered memory deficits or disorders, substantiating the memory issues. Additionally, as noted by Dr. Davis, Respondent's office failed to include in its production of medical records on January 21, 2015 and February 5, 2015 any copies of Form N-648 or its accompanying documents (i.e., copies of MMSE results). These factors, according to Dr. Davis, represented a simple departure from the standard of care.

15. The purpose of a disciplinary action such as this one is to protect the public, and not to punish the licensee. (*Camacho v. Youde* (1979) 95 Cal.App.3d 161, 164; *Small v. Smith* (1971) 16 Cal.App.3d 450, 457.) Complainant seeks revocation. While the record does not establish Respondent's rationale for his apparent and repeated failure to pay close attention to his and his staff's actions, particularly when completing forms under penalty of perjury or maintaining accurate medical records, an appropriate level of discipline to remediate Respondent's conduct should include educational possibilities in connection with a lengthy period of probation, as opposed to revocation. Not only would such action protect the public, it is warranted in light of Respondent's blemish-free 38 year career, not to mention the lack of evidence demonstrating that Respondent benefitted financially or professionally from his actions.

ORDER

Certificate No. A 34248 issued to Respondent, Mahfouz Michael, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for five years, upon the following terms and conditions:

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1. **Education Course**

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. **Medical Record Keeping Course**

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. **Professionalism Program (Ethics Course)**

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of California Code of Regulations, title 16 (CCR), section 1358. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism

program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. **Monitoring - Practice**

Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

5. **Notification**

Within seven days of the effective date of this Decision, Respondent shall provide a true and correct copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

6. **Supervision of Physician Assistants**

During probation, Respondent is prohibited from supervising physician assistants.

7. **Obey All Laws**

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

8. **Quarterly Declarations**

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

9. **General Probation Requirements**

Compliance with Probation Unit:

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes:

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice:

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal:

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California:

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

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10. **Interview with the Board or its Designee**

Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

11. **Non-practice While on Probation**

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

12. **Violation of Probation**

Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

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13. **License Surrender**

Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall, within 15 calendar days, deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

14. **Probation Monitoring Costs**

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

15. **Completion of Probation**

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

Date: October 2, 2017

DocuSigned by:
Carla L. Garrett
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CARLA L. GARRETT
Administrative Law Judge
Office of Administrative Hearings

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Mahfouz Michael, M.D.** **5421 Pacific Blvd.** **Huntington Park, CA 90255-2532** **Physician's and Surgeon's Certificate No. A34248,** Respondent.	Case No. 800-2014-008113 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about August 3, 1979, the Medical Board issued Physician's and Surgeon's Certificate Number A34248 to Mahfouz Michael, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2017, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2229 of the Code states, in subdivision (a):

"Protection of the public shall be the highest priority for the Division of Medical Quality,[1] the California Board of Podiatric Medicine, and administrative law judges of the Medical Quality Hearing Panel in exercising their disciplinary authority."

5. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

6. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

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[1] Pursuant to Business and Professions Code section 2002, the "Division of Medical Quality" or "Division" shall be deemed to refer to the Medical Board of California.

7. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

8. Section 2261 of the Code states:

"Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct."

9. Section 2266 of the Code states: AThe failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

10. Respondent Mahfouz Michael, M.D. is subject to disciplinary action under section 2234, subdivision (b), in that he committed gross negligence in the care and treatment of six patients. The circumstances are as follows:

Patient C.E.

11. On or about April 10, 2014, patient C.E., a 54 year old female patient, visited Respondent's clinic (Clinica Medica San Miguel) where she was seen by Physician Assistant (PA) L.A. for a chief complaint of shoulder pain. The PA noted "rt shoulder pain x 3 weeks, since after fall, pt is experiencing memory deficit, pt does not read, speak neither write English." No further history detail was provided. Multiple elements of systems review and physical exam items were noted in the progress note but there was no documentation of a directed physical evaluation of the right shoulder. The assessment included "memory deficit, hypertension, gastritis, and osteoarthritis as well as right shoulder pain." There was no detail provided to substantiate the "memory deficit." The plan included "refer to neurologist, mini mental state exam [MMSE]," and various lifestyle recommendations.

12. On or about April 17, 2014, the patient was seen for follow up. It was noted that she went only to second grade in Guatemala, does not read, write or speak English, was going to school but was unable to retain new information or concepts. There is a long review of systems and physical exam documented. The assessment included "normal routine history and physical, normal routine history and physical adult, essential hypertension, obesity and memory deficit."

There is not a true diagnosis or reason documented for the assessment of a "memory deficit." A neurology referral and MMSE are mentioned but no follow up is documented on either.

13. On or about April 23, 2014, PA L.A. filled out a Form N-648, Medical Certification for Disability Exceptions for the Department of Homeland Security[2] (DHS) for patient C.E. An MMSE on this day was scored 19/30 indicating severe impairment. Respondent signed off on the Form N-648 indicating that he had personally seen the patient when in fact he had not. The reasons for the patient's disability were listed as memory deficit, hypertension, osteoarthritis, obesity and gastritis. It was noted that memory loss is a "progressive disease that may cause cerebral function to diminish and it is always irreversible. It can be partial or complete or it can produce concentration deficit. The loss of memory can be caused by psychological factors, post – traumatic stress, or after experiencing highly stressing events." No stressful conditions from the patient's life were stated and none were recorded in her medical chart. The indication on the form that the patient needs assistance with basic needs of daily life like cooking, shopping and transportation were not documented in the patient chart. An MMSE score of 20/30 was noted on the form but there was no documentation to support that. The form also noted that the patient had epilepsy but this was not documented in the patient's chart. Genotype disorders are also listed as an etiology of memory deficit. A later MMSE with a score of 20/30 was provided by Respondent but it did not consider her language or education level.

14. On or about April 23, 2014, Respondent was grossly negligent in the care and treatment of patient C.E., separately and taken together, (1) when he signed the Form N-648 indicating that he had seen patient C.E. when in fact he had not; (2) when he listed diagnoses on the form such as epilepsy and genotype disorders that do not have supporting medical documentation; and (3) when he fraudulently certified patient C.E. as being disabled for citizenship purposes.

[2] The form is used to provide the DHS evidence that an applicant for citizenship has a physical or developmental disability or mental impairment that has lasted, or is expected to last, 12 months or more and that prevents him or her (even if provided a reasonable accommodation) from satisfying the English language and/or civics requirements.

15. On or about April 23, 2014, Respondent was grossly negligent in the care and treatment of C.E., separately and taken together, (1) when he used epilepsy and lipid genotypes as a basis for memory deficit contrary to current medical standards or thinking; and (2) asserted that diabetes and hypertension cause memory loss issues contrary to currently held medical fact.

Patient N.C.

16. On or about December 14, 2010, patient N.C. presented to Respondent's clinic for diabetes and hypertension. The patient was thereafter seen by PA L.A. on multiple occasions including October 7, 2011, June 12, 2012, April 1, 2013, October 17, 2013, and January 22, 2014. The patient was seen by another PA on March 1, 2013, who noted, "Memory unimpaired in nml conversation." The patient had poorly controlled diabetes but was cleared for cataract surgery in July 2014. There is no mention in the patient's chart of a functional disability or a memory disorder. There is no mention in the chart that an MMSE was ever administered.

17. On or about April 23, 2014, Respondent signed off on a Form N-648 indicating that he had personally seen the patient when in fact he had not. On the form Respondent indicated that the patient had a memory disorder and that memory disorder is itself a disease which causes brain damage. In addition, he stated that anxiety limits the patient's ability to learn. This is nowhere documented in the patient's chart. Respondent stated on the form that the patient was referred to Neurology but this is not reflected in the patient's chart. Respondent provided a copy of the form with an MMSE attached which was conducted by PA L.A. on April 22, 2014, and scored as 19/30. Respondent listed an MMSE on the Form N-648 as 20/30 but did not note the patient spoke only Spanish or what the patient's educational level was, both of which could have influenced the score.

18. On or about April 23, 2014, Respondent was grossly negligent in the care and treatment of patient N.C., separately and taken together, (1) when he signed the Form N-648 indicating that he had seen patient N.C. when in fact he had not; (2) when he listed diagnoses on the form such as epilepsy and genotype disorders that do not have supporting medical documentation; and (3) when he fraudulently certified patient N.C. as being disabled for citizenship purposes.

19. On or about April 23, 2014, Respondent was grossly negligent in the care and treatment of patient N.C., separately and taken together, (1) when he used epilepsy and lipid genotypes as a basis for memory deficit contrary to current medical standards or thinking; and (2) asserted that diabetes and hypertension cause memory loss issues contrary to currently held medical fact.

Patient E.C.

20. On or about January 27, 2012, patient E.C. was first seen at Respondent's clinic. The patient had diabetes, hypertension and osteoarthritis and was seen on multiple visits.

21. On or about February 17, 2013, the patient complained of tremors. She was referred to Neurology to rule out Parkinson's disease. There is no mention in the patient's chart as to whether she saw a neurologist. There is no follow up regarding the issue of the patient's tremors.

22. On or about April 6, 2014, the patient saw PA L.A. for abdominal pain for three days. There is no mention of memory deficits in the chart for this date or any other date. There was no diagnosis for the abdominal pain but the patient was prescribed Flagyl, an antibiotic. The chart did not contain an MMSE. On this same date, Respondent signed off on a Form N-648 indicating that the patient had a memory disability and that he had personally seen the patient when in fact he had not. Respondent listed on the form diagnoses of epilepsy, memory deficit and genotype disorders, none of which are reflected in the patient's chart. Also listed was an MMSE with a 20/30 score. Respondent subsequently provided an MMSE conducted by PA L.A. which was scored as 19/30.

23. On or about April 6, 2014, Respondent was grossly negligent in the care and treatment of patient E.C., separately and taken together, (1) when he signed the Form N-648 indicating that he had seen patient E.C. when in fact he had not; (2) when he listed diagnoses on the form such as epilepsy and genotype disorders that do not have supporting medical documentation; and (3) when he fraudulently certified patient E.C. as being disabled for citizenship purposes.

24. On or about April 6, 2014, Respondent was grossly negligent in the care and treatment of patient E.C., separately and taken together, (1) when he used epilepsy and lipid

genotypes as a basis for memory deficit contrary to current medical standards or thinking; and (2) asserted that diabetes and hypertension cause memory loss issues contrary to currently held medical fact.

Patient J.L.

25. On or about February 26, 2013, patient J.L. was first seen at Respondent's clinic. The patient had diabetes, hypertension and osteoarthritis and was seen on multiple visits.

26. On or about April 22, 2014, patient J.L. was seen by a another physician at Respondent's clinic. She was there for a mammogram and a pap smear. There is no documentation of memory loss or evidence that an MMSE or neurological exam was conducted that day. Respondent signed off on a Form N-648 indicating that the patient had a memory disability and that he had personally seen the patient when in fact he had not. Respondent listed on the form diagnoses of epilepsy, memory deficit and genotype disorders, none of which are reflected in the patient's chart. An MMSE was noted as 20/30. Respondent subsequently provided an MMSE conducted by PA L.A. that was scored as 19/30.

27. On or about April 22, 2014, Respondent was grossly negligent in the care and treatment of patient J.L., separately and taken together, (1) when he signed the Form N-648 indicating that he had seen patient J.L. when in fact he had not; (2) when he listed diagnoses on the form such as epilepsy and genotype disorders that do not have supporting medical documentation; and (3) when he fraudulently certified patient J.L. as being disabled for citizenship purposes.

28. On or about April 22, 2014, Respondent was grossly negligent in the care and treatment of patient J.L., separately and taken together, (1) when he used epilepsy and lipid genotypes as a basis for memory deficit contrary to current medical standards or thinking; and (2) asserted that diabetes and hypertension cause memory loss issues contrary to currently held medical fact.

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Patient M.A.

29. On or about June 11, 2012, patient M.A., a 66-year-old female, first visited Respondent's clinic. She had ongoing visits thereafter, seeing other providers, including PA L.A. She was diagnosed with essential hypertension, obesity, and bradycardia. She had a normal neurological exam noted at many visits. She was also subsequently diagnosed with diabetes.

30. On or about June 17, 2012, patient M.A. was seen by PA L.A. for a cough; he noted in the chart that the patient "is unable to learn questionary for U.S. citizenship." There is no history or physical exam regarding a memory issue but the assessment includes memory deficit.

31. On or about August 14, 2013, patient M.A. was seen by PA L.A. for low back pain, cough and a foot condition. The PA noted in the chart that the patient was "unable to learn questionary for U.S. citizenship interview." Memory issues were not addressed in the history or exam but memory deficit was stated in the assessment. The plan was to refer her to a neurologist and do a "mini-mental states exam." There is no documentation that either was accomplished.

32. On or about September 10, 2013, the patient was seen again by PA L.A., who charted that she was "unable to learn questionary for U.S. citizenship." He stated that she could not read or write in English or Spanish and had a hearing deficit. "Memory" is not mentioned until it is noted in the assessment as a deficit. The plan was to do a "mini-mental states exam" but none is documented in the chart.

33. On or about April 8, 2014, the patient was seen by PA L.A. More history was listed about the patient's head trauma and hearing deficit. L.A. noted that the patient only attended school to sixth grade and is occasionally forgetful. He diagnosed her with mild memory disturbance following organic brain damage. The plan once again is "mini mental states exam" but again none was charted, although it appeared later that one was performed with the score of 19/30.

34. On or about April 14, 2014, Respondent signed off on a Form N-648 indicating that the patient had a memory disability and that he had personally seen the patient from June 11, 2012, to April 8, 2014, when in fact he had not. For certification of disability for this patient, Respondent listed memory deficit, history of head trauma, hypertension, diabetes, osteoarthritis,

incontinence and hearing deficit. He ascribed the disability to psychological factors or a post traumatic experience due to head trauma. He stated the memory deficit was due to amyloid plaques as well as "lipoprotein E episilon 4 genotype." There is no reference in the medical chart to either of these. Respondent stated that an MMSE was performed with a score of 20/30.

35. On or about September 22, 2014, the patient was seen in the clinic by another physician for back pain. A comprehensive visit was documented but no mention was made of any memory issues or abnormalities. A review of systems in the neurological area was noted as negative. An MMSE was documented as normal.

36. On or about April 14, 2014, Respondent was grossly negligent in the care and treatment of patient M.A., separately and taken together, (1) when he signed the Form N-648 indicating that he had seen patient M.A. when in fact he had not; (2) when he listed diagnoses on the form that were not substantiated by other physicians who saw the patient; and (3) when he fraudulently certified patient M.A. as being disabled for citizenship purposes.

37. On or about April 14, 2014, Respondent was grossly negligent in the care and treatment of patient M.A., separately and taken together, (1) when he used post traumatic disorder, amyloid and lipid genotypes as bases for memory deficit contrary to current medical standards or thinking; (2) asserted that diabetes and hypertension cause memory loss issues contrary to currently held medical fact; and (3) he reported a mini-mental status exam incorrectly and did not take into account the patient's educational and language background, which factors can alter the test results.

Patient A.V.

38. On or about December 30, 2013, patient A.V. was first seen at Respondent's clinic by PA L.A. The patient had a history of moderately differentiated adenocarcinoma of the colon. He had had a low anterior resection surgery with colostomy placement. He was seen for a medication review. He had previously been diagnosed with hypertension, osteoarthritis and diabetes. He was seen on a number of occasions thereafter.

39. On or about April 10, 2014, patient A.V. was seen by PA L.A. as a follow up to an emergency department visit for abdominal pain. The patient was in pain and on narcotic pain

medications. The patient was referred to his oncologist. There was no mention in the chart for this visit or any prior visit of memory issues. There was no referral to neurology charted on this date. Respondent signed off on a Form N-648 indicating that the patient had a memory disability and that he had personally seen the patient when in fact he had not. The form listed memory deficits, cancer, diabetes, hypertension, asthma, osteoarthritis and anxiety as the reasons for the patient's disability. He cited lipid genotypes as bases for memory deficit and he asserted that diabetes and hypertension cause memory loss. He listed an MMSE score of 20/30 but no such test was in the chart. He stated the patient was referred to neurology.

40. On or about April 10, 2014, Respondent was grossly negligent in the care and treatment of patient A.V., separately and taken together, (1) when he signed the Form N-648 indicating that he had seen patient A.V. when in fact he had not; (2) when he listed diagnoses on the form that were not substantiated by documentation in the patient's record; and (3) when he fraudulently certified patient A.V. as being disabled for citizenship purposes.

41. On or about April 10, 2014, Respondent was grossly negligent in the care and treatment of patient A.V., separately and taken together, (1) when he used memory disorder, lipid genotypes, diabetes and hypertension as bases for memory deficit contrary to current medical standards or thinking; and (2) asserted that diabetes, hypertension and epilepsy (which was not previously charted for this patient) cause memory loss issues contrary to currently held medical fact.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

42. Respondent Mahfouz Michael, M.D. is subject to disciplinary action under section 2234, subdivision (c), in that he committed negligence in the care and treatment of six patients. The circumstances are as follows:

Patient C.E.

43. The facts and circumstances alleged in paragraphs 12 through 14 above are incorporated here as if fully set forth.

44. On or about April 23, 2014, Respondent was negligent in the care and treatment of

patient C E., separately and taken together, (1) when he signed the Form N-648 indicating that he had seen patient C.E. when in fact he had not; (2) when he listed diagnoses on the form such as epilepsy and genotype disorders that do not have supporting medical documentation; and (3) when he fraudulently certified patient C.E. as being disabled for citizenship purposes.

45. On or about April 23, 2014, Respondent was negligent in the care and treatment of C.E., separately and taken together, (1) when he used epilepsy and lipid genotypes as a basis for memory deficit contrary to current medical standards or thinking; and (2) asserted that diabetes and hypertension cause memory loss issues contrary to currently held medical fact.

46. On or about April 23, 2014, and thereafter, Respondent was negligent when he failed to maintain copies of the Form N-648 and documents referenced therein (including the MMSE) in the patient's chart.

Patient N.C.

47. The facts and circumstances alleged in paragraphs 17 and 18 above are incorporated here as if fully set forth.

48. On or about April 23, 2014, Respondent was negligent in the care and treatment of patient N.C., separately and taken together, (1) when he signed the Form N-648 indicating that he had seen patient N.C. when in fact he had not; (2) when he listed diagnoses on the form such as epilepsy and genotype disorders that do not have supporting medical documentation; and (3) when he fraudulently certified patient E.C. as being disabled for citizenship purposes.

49. On or about April 23, 2014, Respondent was negligent in the care and treatment of patient N.C., separately and taken together, (1) when he used epilepsy and lipid genotypes as a basis for memory deficit contrary to current medical standards or thinking; and (2) asserted that diabetes and hypertension cause memory loss issues contrary to currently held medical fact.

50. On or about April 23, 2014, and thereafter, Respondent was negligent when he failed to maintain copies of the Form N-648 and documents referenced therein (including the MMSE) in the patient's chart.

Patient E.C.

51. The facts and circumstances alleged in paragraphs 21 through 23 above are

incorporated here as if fully set forth.

52. On or about April 6, 2014, Respondent was negligent in the care and treatment of patient E.C., separately and taken together, (1) when he signed the Form N-648 indicating that he had seen patient E.C. when in fact he had not; (2) when he listed diagnoses on the form such as epilepsy and genotype disorders that do not have supporting medical documentation; and (3) when he fraudulently certified patient E.C. as being disabled for citizenship purposes.

53. On or about April 6, 2014, Respondent was negligent in the care and treatment of patient E.C., separately and taken together, (1) when he used epilepsy and lipid genotypes as a basis for memory deficit contrary to current medical standards or thinking; and (2) asserted that diabetes and hypertension cause memory loss issues contrary to currently held medical fact.

54. On or about April 6, 2014, and thereafter, Respondent was negligent when he failed to maintain copies of the Form N-648 and documents referenced therein (including the MMSE) in the patient's chart.

Patient J.L.

55. The facts and circumstances alleged in paragraphs 26 and 27 above are incorporated here as if fully set forth.

56. On or about April 22, 2014, Respondent was negligent in the care and treatment of patient J.L., separately and taken together, (1) when he signed the Form N-648 indicating that he had seen patient J.L. when in fact he had not; (2) when he listed diagnoses on the form such as epilepsy and genotype disorders that do not have supporting medical documentation; and (3) when he fraudulently certified patient J.L. as being disabled for citizenship purposes.

57. On or about April 22, 2014, Respondent was negligent in the care and treatment of patient J.L., separately and taken together, (1) when he used epilepsy and lipid genotypes as a basis for memory deficit contrary to current medical standards or thinking; and (2) asserted that diabetes and hypertension cause memory loss issues contrary to currently held medical fact.

58. On or about April 22, 2014, and thereafter, Respondent was negligent when he failed to maintain copies of the Form N-648 and documents referenced therein (including the MMSE) in the patient's chart.

Patient M.A.

59. The facts and circumstances alleged in paragraphs 30 through 36 above are incorporated here as if fully set forth.

60. On or about April 14, 2014, Respondent was negligent in the care and treatment of patient M.A., separately and taken together, (1) when he signed the Form N-648 indicating that he had seen patient M.A. when in fact he had not; (2) when he listed diagnoses on the form that were not substantiated by other physicians who saw the patient; and (3) when he fraudulently certified patient M.A. as being disabled for citizenship purposes.

61. On or about April 14, 2014, Respondent was negligent in the care and treatment of patient M.A., separately and taken together, (1) when he used post traumatic disorder, amyloid and lipid genotypes as bases for memory deficit contrary to current medical standards or thinking; (2) asserted that diabetes and hypertension cause memory loss issues contrary to currently held medical fact; and (3) he reported a mini-mental status exam incorrectly and did not take into account the patient's educational and language background, which factors can alter the test results.

62. On or about April 14, 2014, and thereafter, Respondent was negligent when he failed to maintain copies of the Form N-648 and documents referenced therein (including the MMSE) in the patient's chart.

Patient A.V.

63. The facts and circumstances alleged in paragraphs 39 through 40 above are incorporated here as if fully set forth.

64. On or about April 10, 2014, Respondent was negligent in the care and treatment of patient A.V., separately and taken together, (1) when he signed the Form N-648 indicating that he had seen patient A.V. when in fact he had not; (2) when he listed diagnoses on the form that were not substantiated by documentation in the patient's record; and (3) when he fraudulently certified patient A.V. as being disabled for citizenship purposes.

65. On or about April 10, 2014, Respondent was grossly negligent in the care and treatment of patient A.V., separately and taken together, (1) when he used memory disorder, lipid

genotypes, diabetes and hypertension as bases for memory deficit contrary to current medical standards or thinking; and (2) asserted that diabetes, hypertension and epilepsy (which was not previously charted for this patient) cause memory loss issues contrary to currently held medical fact.

66. On or about April 10, 2014, and thereafter, Respondent was negligent when he failed to maintain copies of the Form N-648 and documents referenced therein (including the MMSE) in the patient's chart.

THIRD CAUSE FOR DISCIPLINE

(False Statements)

67. Respondent Mahfouz Michael, M.D. is subject to disciplinary action under section 2261 in that he knowingly signed a document directly related to his practice of medicine which falsely represented the existence or nonexistence of a state of facts in his care and treatment of six patients. The circumstances are as follows:

68. The facts and circumstances alleged in the First Cause for Discipline are incorporated here as if fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Inadequate and Inaccurate Medical Records)

69. Respondent Mahfouz Michael, M.D. is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate and accurate records of the services he provided to patients. The circumstances are as follows:

70. The facts and circumstances alleged in the First Cause for Discipline are incorporated here as if fully set forth.

FIFTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

71. Respondent Mahfouz Michael, M.D. is subject to disciplinary action under section 2234 of the Code in that he engaged in unprofessional conduct. The circumstances are as follows:

72. The facts and circumstances alleged in paragraphs 11 through 71 above are

incorporated here as if fully set forth.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A34248, issued to Mahfouz Michael, M.D.;

2. Revoking, suspending or denying approval of Mahfouz Michael, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Mahfouz Michael, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: November 23, 2016

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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